CHAPTER 4: PRIORITY POPULATIONS AND INTERVENTIONS

Population Priority Setting Process

Population priority setting was accomplished by considering CDC's mandated population of HIV positive persons; size of at-risk populations; measurement of the percentage of HIV morbidity (i.e., HIV/AIDS incidence or prevalence); and prevalence of risky behaviors in the population.

DHEC staff distributed and reviewed the *South Carolina's Epidemiologic Profile* (March 21, 2003) with the CPG. The Needs Assessment Committee reviewed the Epi-Profile and other supplemental data, then presented their recommendations for changing the priority order of populations at the July 23, 2003 CPG meeting. The recommendations were ratified and the following seven (7) priority populations selected and defined by transmission risk, gender, age, race/ethnicity, and HIV status:

1) HIV Positive Persons
2) African American Men who have Sex with Men, Ages 15-44
3) African American Women who have Sex with Men, Ages 15-44
4) African American Men who have Sex with Women, Ages 15-44
5) White Men who have Sex with Men, Ages 15-44
6) Injection Drug Users, Ages 20-44
7) Hispanic/Latino.

Intervention Priority Setting Process

Prior to 2003 the CPG only prioritized health education/risk reduction (HE/RR) interventions. In 2003, the CPG revisited priority interventions to determine if additional intervention types should be included for each population. Using the Behavioral and Social Science Volunteer Program, a local scientist was identified to assist the CPG's Behavioral and Social Science (BSS) Committee with the selection of interventions and strategies for each priority population.

DHEC staff reviewed the different HIV intervention types with the CPG using the *HIV Prevention Programs Health Education Risk Reduction Quality Assurance Guidelines (March 2003)*. The BSS Committee also reviewed the following literature to help identify appropriate interventions.

- Addressing HIV/AIDS…Latino Perspectives & Policy Recommendations by National Alliance of State and Territorial AIDS Directors (NASTAD)
- Compendium of HIV Prevention Interventions with Evidence of Effectiveness from CDC's HIV/AIDS Prevention Research Synthesis Project
- Fact Sheets of Effective HIV Prevention Interventions compiled by Health Education Training Centers Alliance of Texas – San Antonio, University of Texas Southwestern Medical Center - Dallas, Texas Department of Health - Austin

- Incorporating HIV Prevention into the Medical Care of Persons Living with HIV HIV/AIDS: African American Perspectives and Recommendations for State and Local AIDS Directors and Health Departments by CDC
- Advancing HIV Prevention: New Strategies for a Changing Epidemic – United States, 2003 by CDC

Based on the literature review and DHEC staff presentation, the BSS Committee recommended the following intervention types to the CPG in July 2003. The CPG ratified the recommendations and the following interventions were selected for each priority population.

Below is a summary table.

TARGET POPULATIONS BY RANK ORDER	INTERVENTIONS TYPES, NOT RANKED
1. HIV Positive Persons	Individual Level Intervention Group Level Intervention – Support Group Outreach Prevention Case Management Counseling & Testing Partner Counseling and Referral Services
2. African American Men who have Sex with Men (AAMSM), Ages 15-44	Individual Level Intervention Group Level Intervention – Skills Building Prevention Case Management Counseling & Testing Partner Counseling and Referral Services Capacity Building Community Level Intervention
3. African American Women who have Sex with Men (AAWSM), Ages 15-44	Individual Level Intervention Group Level Intervention – Skills Building Prevention Case Management Counseling & Testing Partner Counseling and Referral Services Capacity Building Community Level Intervention
4. African American Men who have Sex with Women (AAMSW), Ages 15-44	Individual Level Intervention Group Level Intervention – Skills Building Prevention Case Management Counseling & Testing Partner Counseling and Referral Services Capacity Building Community Level Intervention
5. White Men who have Sex with Men (WMSM), Ages 15-44	Group Level Intervention – Skills Building Prevention Case Management Counseling & Testing Partner Counseling and Referral Services

	Community Level Intervention
6. Injection Drug Users (IDU), Ages 20-44	Individual Level Intervention Group Level Intervention – Skills Building Outreach Prevention Case Management Counseling & Testing Partner Counseling and Referral Services Community Level Intervention Other
7. Hispanic/Latino	Individual Level Intervention Group Level Intervention – Skills Building Group Level Intervention – Support Group Outreach Prevention Case Management Counseling & Testing Partner Counseling and Referral Services Health Communication/Public Information Capacity Building

Priority Population and Interventions For 2005-2008

On the following pages are the detailed recommendation sheets presented to the CPG in July 2003 for ratification. These were reviewed again in August 2004 for inclusion in the revised plan for 2005-2008. Each description includes the estimated size of the population, sub-populations of interest, summary of needs from the needs assessment study (Chapter 2), primary risk behaviors to be targeted, intervention goals or outcomes, a table that summarizes the resource information reviewed and key findings from the literature, and a detailed bibliographic listing of the resources reviewed by the CPG Needs Assessment Workgroup and the Behavioral and Social Sciences Committees.

POPULATION: #1 HIV POSITIVE PERSONS

Size of Population: 19,462

As of December 31, 2003, there were 19,462 persons cumulatively reported with HIV, and of them, 13,213 have been diagnosed with AIDS. The growing number of persons living with HIV challenges both prevention and care service systems. Prevention needs are essential as sexual and substance use risk behaviors are occurring among persons living with HIV. Interviews with recently diagnosed persons with HIV indicate substance use during past 5 years or present was reported by one-third of persons with HIV interviewed: 30% reported potential alcoholic, 40% used illicit drugs during past five years. Nine percent reported ever injecting drugs and 16% had used. Sexual risks reported by persons interviewed indicate that one-fourth (28%) of men paid some one for sex; 9% of women received either money or drugs for sex. Thirty percent of men and 23% of women reported having at least one sexually transmitted disease (STD) during the past ten years.

Sub-Populations of Interest:
AAMSM and WMSM
AAMSW and AAWSM
IDU

Needs Assessment Summary:
–High incidence of unprotected sex
–High incidence of STD/history of STD's
–Misinformation & lack of knowledge about HIV risky behaviors & transmission
–Multiple sexual partners
–Non-injection drug/substance use
–Lack of drug treatment programs and/or access to such
–High incidence of commercial sex work
–Low SES (education, income & employment)
–Inadequate support services for PLWH/A
–Frustration, hopelessness & resignation
–Mental health issues
–Limited access to & utilization of health & social services (health insurance, adherence & compliance, transportation, etc.).
–Social stigma, discrimination & phobias
–Little or no follow-up care or linkages to needed services
–Inadequate outreach services
–Unmet necessary needs (shelter, food, etc.)
–Low sensitivity, empathy and confidentiality by health care providers

Risk Behavior: Unprotected Sex

Intervention Goals: 1) Implement new models for diagnosing HIV infections outside medical settings; 2) Prevent new infections by working with persons diagnosed with HIV and their partners.

Intervention Goals/Outcomes:
1. Reduce Harm to Self
   - Prevent reinfection with another strain of HIV
   - Prevent the acquisition of other sexually transmitted infections (STIs)
2. Reduce Harm to Others
   - Reduce exposure of sexual or injection risk behavior that can transmit HIV, including drug resistant strains of HIV, to HIV-negative persons
   - Reduce sexual risk behavior that can transmit other STIs

Note: For interventions specific to injection drug users see Intervention Recommendation Sheet for populations #6.

INTERVENTION TYPES Note: Refer to "HIV Prevention Programs Quality Assurance Guidelines" for more detailed information on specific intervention types.	**WHY?**
A. Individual Level Interventions (ILI)	A. ILI: (3, **4**, 5, 6, 7) *CDC recommended.*
B. Prevention Case Management (PCM)	B. PCM: Results of a CDC and HRSA-sponsored study indicate that HIV–infected persons who received ongoing HIV prevention case management adopted and sustained selected safer sexual practices during the six-month follow-up period. (1, 2, 3, **5**, 7, 8, 9) *CDC required.*
C. Outreach (OUT)	C. OUT: Organizations should approach and enlist HIV-infected clients to identify or recruit -- from their social, sexual, or drug-using networks --persons who may be likely to be infected with HIV but are not yet aware of their infection. (1, 3, 6, 7, **10**) *CDC recommended.*
D. Group Level Intervention--Support Groups (GLI-SG)	D. GLI--SG: (**3**, 6, 7, 9) *Among CDC-funded PHIPP demonstration interventions.*
E. Counseling and Testing (CT) – includes Community Based Counseling and Testing (CBC&T)	E. CT: Many persons who learn that they are HIV infected adopt behaviors that might reduce the risk for transmitting HIV. (**1**, **2**, 3, 4, 6, 7) *CDC required.*
F. Partner Counseling and Referral Services (PCRS)	F. PCRS: 8% - 39% of partners tested in studies of partner counseling and referral services were found to have previously undiagnosed HIV infection. (**1**, 3, 4) *CDC required.* *Note: Numbers represent references in resource section below.* ***Bold typed*** *number above indicates primary reference or resource.*

Resources:

1. Centers for Disease Control and Prevention. *MMWR*, 2003; vol. 52, no 15. "Advancing HIV Prevention: New Strategies for a Changing Epidemic – United States, 2003."

2. Centers for Disease Control and Prevention, National Center for HIV, STD and TB Prevention. "SAFE, A Serostatus Approach to Fighting the HIV/AIDS Epidemic," (The CDC Prevention for HIV-Infected Persons Project [PHIPP]), 2001. www.cdc.gov/nchstp/od/program_brief_2001/AIDS%20Epidemic.

3. Centers for Disease Control and Prevention. "PHIPP Project Fact Sheets," July 2002.

4. Centers for Disease Control and Prevention. *MMWR*, 2003, vol. 52, no. RR12. "Incorporating HIV Prevention into the Medical Care of Persons Living with HIV".

5. National Academies Press, Institute of Medicine. *No Time to Lose: Getting More from HIV Prevention*. "Chapter 4: Using The Clinical Setting," pp. 50 – 67, 2001.

6. University of California, San Francisco, AIDS Policy Research Center and Center for AIDS Prevention Studies, AIDS Research Institute. "Prevention with Positives Resources," http://ari.ucsf.edu/policy/pwp.

7. AIDS Partnership California. "HIV Prevention with Positives Resources." www.aidspartnershipca.org/pfp.

8. Centers for Disease Control and Prevention. *HIV Prevention Case Management Guidance*, September 1997.

9. University of California, San Francisco, AIDS Policy Research Center and Center for AIDS Prevention Studies, AIDS Research Institute. "Designing Primary Prevention for People Living with HIV," Collins, C., et al, March 2000.

10. Centers for Disease Control and Prevention. "Solicitation for CDC Community Based Organization Demonstration Projects 2003-N-00895."

11. www.cdc.gov/hiv/partners/ahp.htm

POPULATION: #2 AFRICAN AMERICAN MEN WHO HAVE SEX WITH MEN

Estimated Size: Minimum of 28,659 men, ages 15 - 44

There are significant prevention challenges related to African American Men Who Have Sex With Men (AAMSM) in South Carolina, similar to other southeastern states. Few programs are targeted toward this population, and even fewer of the existing programs have demonstrated success in reaching them. Access to the population is difficult due to secrecy of the activity, denial of African American MSM engaging in same sex activities and the double stigmas of racism and homophobia. The majority of AAMSM often identify themselves as heterosexual. Thus, there is not a defined open "community" to focus needs assessments, target information or provide support. Further, the lack of family and religious institution support of sexuality issues reduces the population's access to preventive health services. There is a lack of information on proven effective interventions for this population, particularly in rural areas. Culturally reflective staff, including peers, are often not available to deliver the interventions.

Subpopulations Of Concern:

- HIV Negative Partners of HIV Positive Persons
- Youth and young adults (<25)
- Incarcerated
- Substance users*
- HIV infected*
- Bisexual
- Transgenders
- Sex workers

Needs Assessment Findings:

–Unified gay community
–Financial and generation gap within community
–Apathy about HIV/AIDS
–Lack of accessible social, cultural & health information /resources
–Lack of alternative non-bar meeting/gathering places
–High incidence of drug use
–High incidence of commercial sex
–High incidence of unprotected sex
–High incidence of closeted (down-low) sexual behaviors
–Language and cultural barriers for subsets of the community
–High incidence of unknown HIV status, and unwillingness to be tested, and/or lack of awareness of benefits of testing/testing sites
–Misinformation & lack of knowledge about HIV risky behaviors and transmission
–Multiple sexual partners
–Non-injection drug use
–High rate of low SES
–Prevalence of societal discrimination & stigma related to race, sexual orientation & economic status
–High incidence of STD/history of STD's

Risk Behavior: Unprotected Sex

Intervention Goals/Outcomes:

1) Abstain/postpone sexual intercourse, 2) Increase the correct and consistent use of condoms, 3) Reduce number of sexual partners, 4) Increase knowledge of their HIV status, 5) Reduce substance use/abuse in sexual situations

* For interventions specific to HIV positive persons and injection drug users see Intervention Recommendation Sheets for populations #1 and #6.

INTERVENTION TYPES Note: Refer to "*HIV Prevention Programs Quality Assurance Guidelines*" for more detailed information on specific intervention types.	**WHY?**
A. Individual Level Intervention (ILI)	A. ILI: One-to-one counseling, specially tailored to the particular behaviors practiced by each man, might be useful in preventing new HIV infections. This statement was taken from a document entitled "Explore Baseline Papers Summary". (14, 15)
B. Group Level Interventions – Skills Building (GLI-SB)	B. GLI - SB: New research showed that group interventions were more effective than education for STD/HIV prevention. This statement was taken from Many Men, Many Voices brochure. (8, 10, 11, 12, 13)
C. Group Level Interventions – Support Group (SG)	C. GLI-SG: Awaiting documentation from Dr. J. White.
D. Counseling and Testing (CT) – includes Community Based Counseling and Testing (CBC&T)	D. CT: Many persons who learn that they are HIV infected adopt behaviors that might reduce the risk for transmitting HIV. (**1, 2**, 6) *CDC required*.
E. Capacity Building (CB)	E. CB: The Committee identified and focused on two areas of capacity building: (a) capacity building within health departments – to ensure effective service delivery to African American communities at highest risk, and (b) capacity building within CBOs – to ensure effective delivery of services to African American client populations (particularly transgenders, IDUs, women, MSM, young people as they are at highest risk). (**9**)
F. Community Level Intervention (CLI)	F. CLI: CDC recognized as an effective intervention. (**7**) *Note: Numbers represent references in resource section below.* ***Bold typed*** *number above indicates primary reference or resource. .*

Resources:

1. Centers for Disease Control and Prevention. *MMWR*, 2003; vol. 52, no. 15. "Advancing HIV Prevention: New Strategies for a Changing Epidemic – United States, 2003."

2. Centers for Disease Control and Prevention, National Center for HIV, STD and TB Prevention. "SAFE, A Serostatus Approach to Fighting the HIV/AIDS Epidemic," (The CDC Prevention for HIV-Infected Persons Project [PHIPP]), 2001. www.cdc.gov/nchstp/od/program_brief_2001/AIDS%20Epidemic.

3. *American Journal of Public Health*, vol. 81 (2), pp. 168 – 171. "HIV Risk Behavior Reduction Following Intervention with Key Opinion Leaders of Population: An Experimental Analysis," Kelly, JA, et al, 1991.

4. Centers for Disease Control and Prevention. *Evaluation Guidance Handbook: Strategies for Implementing the Evaluation Guidance for CDC-Funded HIV Prevention Programs*. "Chapter Nine: Guidance FAQs," pp. 69 – 70, March 2002.

5. *American Journal of Public Health*, vol. 84, pp. 1938 – 1946. "Factors Mediating Changes in Sexual HIV Risk Behaviors Among Gay and Bisexual Male Adolescents," Rotheram-Borus, M., et al, 1994.

6. Centers for Disease Control and Prevention. *No Turning Back: Addressing The HIV Crisis Among Men Who Have Sex With Men*, November 2001.

7. Centers for Disease Control and Prevention. "Compendium of HIV Prevention Interventions with Evidence of Effectiveness." Altlanta, GA: US Department of Health and Human Service, CDC; 1999 (Revised 2001). Available at www.cdc.gv/hiv/pubs/HIVcompendium/hivcompendium/pdf.

8. Peterson, J.L.; Coates, T.J.; Catania, J.; hauck, W.W.; Acree, M.; Daigle, D.; Hillard, B.; Middleton, L.; Hearst, N. "Evaluation of an HIV Risk Reduction Intervention Among African-American Homosexual and Bisexual Men." *AIDS* 1996, 10 (3): 319-25.

9. National Alliance of State and Territorial AIDS Directors. "HIV/AIDS: African American Perspectives and Recommendations for State and Local AIDS Directors and Health Departments." Washington, DC, NASTAD; 2003. Available at www.nastad.org/documents/public/pub_prevention/2002219HVADSAfricanAmericanPerspectivesandRecommendations.pdf

10. Coury-Doniger P.; Knox, K.; Morgan, J.; Jenersen, E.; McGrath, P.; Scahill, M.; Roberson, M.; English, G. "The Development of a Science-based HIV Prevention Intervention for Gay Men of Color." Abstract presented at the National HIV Prevention Conference, August, 2001. Atlanta, GA.

11. Scahill, M.; McGrath, P., Berkhoudt, K.; English, G.; Morgan, J.; Urban, M.; Coury-Doniger, P. "Many Men, May Voices: A Science-based Prevention Intervention for Gay Men of Color." Abstract presented at the National STD Prevention Conference, March 2002.

12. Kelly, J.A.; Lawrence, J.S.; Hood, H.V.; Brasfield, T.L. (1989). "Behavioral Intervention to reduce AIDS Risk Activities." *Journal of Consulting and Clinical Psychology*, 57 (1), p. 60-67.

13. Kelly, J.A. (1995). Changing HIV Risk Behavior: Practical Strategies. The Guilford Press, New York, New York. p. 1-59.

14. Beryl A. Koblin, Margaret A. Chesney, Marla J. Husnik, Sam Bozeman, Connie L. Celum, Susan Buchbinder, Kenneth Mayer, David McKirnan, Franklyn N. Judson, Yijian Huang, Thomas J. Coates, and the EXPLORE Study Team. "High-Risk Behaviors Among Men Who Have Sex With Men in 6 US Cities: Baseline Data From the EXPLORE Study." *American Journal of Public Health* 2003 93 926-932. Available at www.explorestudy.org

15. Margaret A. Chesney, Beryl A. Koblin, Patrick J. Barresi, Marla Husnik, Connie L. Celum, Gran Colfax, Kenneth Mayer, David McKirnan, Franklyn N. Judson, Yijian Huang, Thomas J. Coastes, and the EXPLORE Study Team. "An Individually Tailored Intervention for HIV Prevention: Baseline Data From the EXPLORE Study." *American Journal of Public Health* 2003 93: 933-938. Available at www.explorestudy.org

POPULATION: #3 AFRICAN AMERICAN WOMEN WHO HAVE SEX WITH MEN

Estimated Size: 317,396 women, ages 15 - 44

African American women comprise nearly one quarter of the persons living with HIV (25%) in South Carolina, the second highest proportion following African American men. Among recently reported cases during 2003, African American women accounted for 30% of the total reported cases, compared to 15% among white men and 4% white women. This trend is similar across southern states where joblessness, substance abuse, teenage pregnancy, STD's inadequate schools, minimal access to health care and low incomes contribute to the increasing rates of HIV among this population. In addition, African American women are frequently unknowingly placed at risk by their male sexual partners who are more likely to be HIV infected through male to male sex and substance use. Women are often in power imbalanced relationships and perceive themselves as "victims" which creates significant challenges for prevention.

Subpopulations of Concern:

- HIV Negative Partners of HIV Positive Persons
- Youth and young adults (<25)
- Incarcerated
- Substance users*
- HIV infected*
- Sex workers
- Pregnant women

Needs Assessment Findings:

–High incidence of unprotected sex
–High incidence of STD/history of STD's
–Misinformation & lack of knowledge about HIV risky behaviors and transmission
–Multiple sexual relationships
− High incidence of commercial sex work
− Low SES (education, income and employment)
− Non-injection drug use
− Inadequate health, social and support services (transportation, health insurance, child care, etc.).

Risk Behavior: Unprotected Sex

Intervention Goals/Outcomes:

1) Abstain/postpone sexual intercourse, 2) Increase the correct and consistent use of condoms, 3) Reduce number of sexual partners, 4) Increase knowledge of their HIV status, 5) Reduce substance use/abuse in sexual situations

* For interventions specific to HIV positive persons and injection drug users see Intervention Recommendation Sheets for populations #1 and #6.

INTERVENTION TYPES Note: Refer to "*HIV Prevention Programs Quality Assurance Guidelines*" for more detailed information on specific intervention types.	**WHY?**
A. Individual Level Interventions (ILI)	A. ILI: CDC recognized as an effective intervention. (**2**)

B. Group Level Interventions – Skills Building (GLI-SB)	B. GLI - SB: CDC recognized as an effective intervention. (**2**)
C. Counseling and Testing (CT) – includes Community Based Counseling and Testing (CBC&T)	C. CT: CDC required. (**3**)
D. Capacity Building (CB)	D. CB: The Committee identified and focused on two areas of capacity building: (a) capacity building within health departments – to ensure effective service delivery to African American communities at highest risk, and (b) capacity building within CBOs – to ensure effective delivery of services to African American client populations (particularly transgenders, IDUs, women, MSM, young people as they are at highest risk). (**1**)
E. Community Level Intervention (CLI)	E. CLI: CDC recognized as an effective intervention. (**2**) *Note: Numbers represent references in resource section below.* ***Bold typed*** *number above indicates primary reference or resource.*

Resources:

1. National Alliance of State and Territorial AIDS Directors. "HIV/AIDS: African American Perspectives and Recommendations for State and Local AIDS Directors and Health Departments." Washington, DC, NASTAD; 2003. Available at www.nastad.org/documents/public/pub_prevention/2002219HVADSAfricanAmericanPerspectivesandRecommendations.pdf

2. Centers for Disease Control and Prevention. "Compendium of HIV Prevention Interventions with Evidence of Effectiveness." Atlanta, GA: US Department of Health and Human Service, CDC; 1999 (Revised 2001). Available at www.cdc.gv/hiv/pubs/HIVcompendium/hivcompendium/pdf.

3. Centers for Disease Control and Prevention. *MMWR*, 2003; vol. 52, no. 15. "Advancing HIV Prevention: New Strategies for a Changing Epidemic – United States, 2003."

POPULATION: #4 AFRICAN AMERICAN MEN WHO HAVE SEX WITH WOMEN

Estimated Size: 257,928 men, ages 15 -44

African American men comprise approximately one-third of persons living with HIV due to heterosexual transmission (31%) and 35% of more recently diagnosed heterosexual cases. Many local HIV providers believe the proportion of African American men reporting heterosexual transmission is inflated due to stigma of male to male sex. However, it is recognized that many of these men have sex with women and as the number of African American women infected with HIV grows, the heterosexual risk to men will also grow. Additionally, many important programs developed by and for the African American community often focus more on women. African American men have fewer services provided specifically to meet their needs.

Subpopulations of Concern:

- HIV Negative Partners of HIV Positive Persons
- Men older than 25 years
- Incarcerated
- Substance users*
- HIV infected*

Needs Assessment:

–High incidence of unprotected sex
–High incidence of STD/history of STD's
–Misinformation & lack of knowledge about HIV risky behaviors and transmission
–Multiple sexual partners
–Non-injection drug use
–High incidence of commercial sex work
–Low SES (education, income and employment)
–Inadequate health, social and support services (transportation, health insurance, child care, etc.).
–Apathy to HIV status

Risk Behavior: Unprotected Sex

Intervention Goals/Outcomes:

1) Abstain/postpone sexual intercourse, 2) Increase the correct and consistent use of condoms, 3) Reduce number of sexual partners, 4) Increase knowledge of their HIV status, 5) Reduce substance use/abuse in sexual situations

* For interventions specific to HIV positive persons and injection drug users see Intervention Recommendation Sheets for populations #1 and #6.

INTERVENTION TYPES Note: Refer to "*HIV Prevention Programs Quality Assurance Guidelines*" for more detailed information on specific intervention types.	**WHY?**
A. Individual Level Interventions (ILI)	A. ILI: CDC recognized as an effective intervention. (**2**)
B. Group Level Interventions – Skills Building (GLI-SB)	B. GLI - SB: CDC recognized as an effective intervention. (**2**)

C. Counseling and Testing (CT) – includes Community Based Counseling and Testing (CBC&T)	C. CT: CDC required. (**3**)
D. Capacity Building	D. CB: The Committee identified and focused on two areas of capacity building: (a) capacity building within health departments – to ensure effective service delivery to African American communities at highest risk, and (b) capacity building within CBOs – to ensure effective delivery of services to African American client populations (particularly transgenders, IDUs, women, MSM, young people as they are at highest risk). (**1**)
E. Community Level Intervention (CLI)	E. CLI: CDC recognized as an effective intervention. (**2**) *Note: Numbers represent references in resource section below.* ***Bold typed*** *number above indicates primary reference or resource.*

Resources:

1. National Alliance of State and Territorial AIDS Directors. "HIV/AIDS: African American Perspectives and Recommendations for State and Local AIDS Directors and Health Departments." Washington, DC, NASTAD; 2003. Available at www.nastad.org/documents/public/pub_prevention/2002219HVADSAfricanAmericanPerspectivesandRecommendations.pdf

2. Centers for Disease Control and Prevention. "Compendium of HIV Prevention Interventions with Evidence of Effectiveness." Altlanta, GA: US Department of Health and Human Service, CDC; 1999 (Revised 2001). Available at www.cdc.gv/hiv/pubs/HIVcompendium/hivcompendium/pdf.

3. Centers for Disease Control and Prevention. *MMWR*, 2003; vol. 52, no. 15. "Advancing HIV Prevention: New Strategies for a Changing Epidemic – United States, 2003."

POPULATION: #5 WHITE MEN WHO HAVE SEX WITH MEN

Estimated Size: Minimum of 16,437 men, 15 – 44 years of age

Men who have sex with men (MSM) continue to remain a significantly affected population with HIV, regardless of age, race/ethnicity and residence. The largest proportion of persons estimated to be living with HIV in the state are men who have sex with men. The level of new HIV cases appears to be declining among white MSM. However, further assessments need to occur to determine if testing patterns have changed (particularly among young men under 25 years) or if there are other factors to confirm if "incident" cases are truly declining. Most white MSM live in the more urban counties and may have more sense of community than exists with African American MSM, reducing some of the prevention barriers. Most white MSM infected with HIV are older than 25 years of age. Increases in very high risk behaviors among young MSM living in other areas of the country, however, is cause for concern among young MSM in South Carolina.

Subpopulations of Concern:

- HIV Negative Partners of HIV Positive Persons
- Youth and young adults (<25)
- Substance users*
- HIV infected*
- Sex workers
- Older adults (>44)
- Internet "cruisers"

Needs Assessment:

–Unified gay community
–Generation gap within community
–Apathy about HIV/AIDS
–Lack of alternative non-bar meeting/gathering places
–High incidence of drug use
–High incidence of commercial sex
–Prevalence of societal discrimination & stigma relating to race, sexual orientation & economic status
–High incidence of unprotected sex
–Language and cultural barriers for subsets of the community
–High incidence of STD/history of STD's
–Misinformation & lack of knowledge about HIV risky behaviors and transmission
–Multiple sexual partners
–Non-injection drug use
–Misconceptions about HIV/AIDS antiretroviral drugs & therapy

Risk Behavior: Unprotected Sex

Intervention Goals/Outcomes:

1) Abstain/postpone sexual intercourse, 2) Increase the correct and consistent use of condoms, 3) Reduce number of sexual partners, 4) Increase knowledge of their HIV status, 5) Reduce substance use/abuse in sexual situations

* For interventions specific to HIV positive persons and injection drug users see Intervention Recommendation Sheets for populations #1 and #6.

INTERVENTION TYPES Note: Refer to "*HIV Prevention Programs Quality Assurance Guidelines*" for more detailed information on specific intervention types.	**WHY?**
G. Counseling and Testing (CT) – includes Community Based Counseling and Testing (CBC&T)	A. CT: Many persons who learn that they are HIV infected adopt behaviors that might reduce the risk for transmitting HIV. (**1, 2,** 8) *CDC required.*
H. Capacity Building (CB) & Outreach (OUT)	B. CB/OUT: CDC recognized as an effective intervention. (3, 4, 5, 8, **9**). See *, **, *** in the Resources.
I. Group Level Interventions – Skills Building (GLI-SB)	C. GLI – SB: CDC recognized as an effective intervention (6, 7, 8, **9**). See** in the Resources. *Note: Numbers represent references in resource section below.* ***Bold typed*** *number above indicates primary reference or resource.*

Resources:

1. Centers for Disease Control and Prevention. *MMWR*, 2003; vol. 52, no. 15. "Advancing HIV Prevention: New Strategies for a Changing Epidemic – United States, 2003."

2. Centers for Disease Control and Prevention, National Center for HIV, STD and TB Prevention. "SAFE, A Serostatus Approach to Fighting the HIV/AIDS Epidemic," (The CDC Prevention for HIV-Infected Persons Project [PHIPP]), 2001. Available at www.cdc.gov/nchstp/od/program_brief_2001/AIDS%20Epidemic.

3. *American Journal of Public Health*, vol. 81 (2), pp. 168 – 171. "HIV Risk Behavior Reduction Following Intervention with Key Opinion Leaders of Population: An Experimental Analysis," Kelly, JA, et al, 1991.

4. *American Journal of Public Health*, vol. 86 (8), pp. 1129 – 1136. "The Mpowerment Project: A Community-level HIV Prevention Intervention for Young Gay Men," Kegeles, S.M., et al, 1996.

5. Centers for Disease Control and Prevention. *Evaluation Guidance Handbook: Strategies for Implementing the Evaluation Guidance for CDC-Funded HIV Prevention Programs*. "Chapter Nine: Guidance FAQs," pp. 69 – 70, March 2002.

6. *AIDS*, vol. 3 (1), pp. 21 – 26. "AIDS Prevention in Homosexual and Bisexual Men: Results of a Randomized Trial Evaluating Two Risk Reduction Interventions," Valdiserri, R.O., et al., 1989.

7. *Journal of Consulting and Clinical Psychology*, vol. 57 (1), pp. 60 – 67. "Behavioral Intervention to Reduce AIDS Risk Activities," Kelly, JA, et al, 1989.

8. Centers for Disease Control and Prevention. *No Turning Back: Addressing The HIV Crisis Among Men Who Have Sex With Men*, November 2001.

9. Centers for Disease Control and Prevention. "Compendium of HIV Prevention Interventions with Evidence of Effectiveness." Altlanta, GA: US Department of Health and Human Service, CDC; 1999 (Revised 2001). Available at www.cdc.gv/hiv/pubs/HIVcompendium/hivcompendium/pdf.

POPULATION: #6 INJECTION DRUG USERS

Estimated Size: 8,000 (All races/sexes)

There is an apparent decline in the number of HIV infections reported among both men and women due to injecting drug use (IDU). Among the estimated number of persons living with HIV who are IDU's, the majority of African American men (56%) compared to 18% are white men. African American women account for 15% of recent cases due to injecting drug use; white women account for 9%. The majority (96%) of recently diagnosed IDU cases are among persons 25 – 45 and above. The urban areas have more persons living with HIV due to injecting use. Due to legal barriers, South Carolina does not have needle exchange programs, which limits effective prevention efforts for this population. Other barriers include South Carolina's legal policy of reporting pregnant substance users (including IDUs) for prosecution which may deter women from seeking early and regular prenatal care.

Subpopulations of Concern:

- HIV Negative Partners of HIV Positive Persons
- Persons older than 25 years
- Incarcerated
- Substance users
- HIV infected*
- Sex workers
- Homeless
- Pregnant women

Needs Assessment:

–Co-existence of HIV infection and substance use
–Lack of availability and access to drug treatment
–Inadequate linkage and/or follow-up services
–Non-integration of physical and psychosocial needs of patients
–Non-integration of HIV/AIDS & drug treatment services/programs
–Non-expansive nature of drug treatment services
–Non-gender specific drug treatment programs

Risk Behavior: 1) Unsafe needle sharing practices; and 2) Unprotected Sex

Intervention Goals/Outcomes:

Drug Behaviors - 1) Abstain from using drugs; 2) Abstain from unsafe needle sharing practices; 3) Increase the correct and consistent cleaning of injection equipment; 4) Refer to a treatment facility; 5) Increase knowledge of their HIV status

Sex Behaviors -1) Abstain/postpone sexual intercourse, 2) Increase the correct and consistent use of condoms, 3) Reduce number of sexual partners, 4) Increase knowledge of their HIV status, 5) Reduce substance use/abuse in sexual situations

* For interventions specific to HIV positive persons see Intervention Recommendation Sheet for populations #1.

INTERVENTION TYPES Note: Refer to "*HIV Prevention Programs Quality Assurance Guidelines*" for more detailed information on specific intervention types.	**WHY?**
A. Individual Level Interventions (ILI)	ILI: Prevention interventions must be personalized for each person at risk. Effective prevention requires more than simply passing out information and risk-reduction supplies. Persons at risk must be engaged in a personalized assessment of their own risk behaviors, assisted in identifying barriers to and resources available to help them change their behavior, and helped to formulate specific and achievable strategies to protect themselves and others. (**1**)
B. Group Level Interventions – Skills Building (GLI-SB)	GLI – SB: CDC recognized as an effective intervention. (**3,** 6, 7, 8, 9)
C. Outreach (OUT)	OUT: Outreach is viewed as an essential component of HIV prevention efforts targeting out-of-treatment drug users. Because drug use is a highly stigmatized illegal activity, drug users and their sexual partners may be difficult to access through traditional medical and social service agencies. Outreach conducted by individuals indigenous to the local community and familiar with drug use subcultures has been found to be highly effective in accessing out-of-treatment drug users and initiating behavior change. (**1**,2)
D. Counseling and Testing (CT) – includes Community Based Counseling and Testing (CBC&T)	CT: CDC required. (**4,** 12)
E. Community Level Interventions (CLI)	CLI: CDC recognized as an effective intervention. (**3**, 5)

F. Other (Access to Sterile Syringes)	OTH: Clearly, the best solution for injecting drug users is to stop injecting and enter substance abuse treatment. However, many drug users either cannot get into substance abuse treatment programs or will not stop injecting drugs. Even those injectors who are in treatment may relapse to injecting drugs. Given these realies, several governmental bodies and institutions have recommended consistent, one-time-only use of sterile syringes as a central strategy in the effort to reduce the transmission of HIV and other blood-borne pathogens among those individuals who continue to inject drugs. (1, **10**) *Note: Numbers represent references in resource section below. **Bold typed** number above indicates primary reference or resource.*

Resources:

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11. Academy for Educational Development (AED). "HIV Prevention Among Drug Users: A Resource Book for Community Planners & Program Managers". Washington (DC): Academy for Educational Development; 1997. Funding provided under Centers for Disease Control and Prevention contract number 200-91-0906. Available at www.cdc.gov/idu/idu.htm.

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POPULATION: #7 LATINO/A OR HISPANIC

Estimated Size: 95,076

Two percent of total persons living with HIV infection are Hispanics, who comprise about 2.4% of the state's population (2003 estimates). While the general population has grown 15.1% in the period from 1990 to 2000, the Hispanic Population grew from 30,500 to 95,076 in the same period, a 211.71% growth. The US Census reports this number could double to 190,152 by 2010. The Counties with the highest Hispanic population growth are: Jasper 1,624.6%; Saluda: 1,529.1%; Newberry: 942%; and Hampton 670.4%. Most of this increase can be attributed to high levels of migration due to economic opportunities in agriculture, construction and food industries, as well as high Hispanic birth rates. This rapid growth has considerable implications for the health status of this medically under-served population. This growth has surpassed the ability of health care providers to provide adequate services to this group of people. Meeting the health care needs of Hispanics requires an understanding of their social, cultural, economic, and physical environments.

Hispanics in South Carolina face many barriers to health care and HIV education including language, lack of transportation, geographic inaccessibility, and financial constraints. Similarly, substance abuse, health risk behaviors (e.g. smoking, unhealthy dietary practices), and the occupational hazards of migrant work add to the risk of disability and chronic illness. At the same time, health care providers face certain barriers that make it difficult to offer adequate services to the Hispanic community such as shortages of bilingual and bicultural health care providers, and trained interpreters, at health care centers. As a result of these barriers, Hispanics are limited as to the quality and quantity of health care information they receive.

The enormous diversity within Latino communities, representing many different countries with diverse cultures and HIV risk factors makes dealing with HIV/AIDS especially complex and challenging. SC Hispanic Outreach –a non-profit organization- conducted an HIV/AIDS Awareness Survey among the Hispanic Community. A total of 450 individuals were interviewed for this needs assessment. These interviews were conducted in the counties of Richland, Lexington, Fairfield and Newberry in farms, migrant camps, apartment complexes, Mexican stores and other places where Hispanics were highly concentrated. Some of the findings of the HIV/AIDS Awareness Survey are presented here:

Percentages of Selected Demographic Characteristics from HIV/AIDS Awareness Survey (n=450)

Demographic		Percent	Demographic	Percent	Demographics	Demographic
Sex	Males	38%	**Origin**		**Education**	
	Females	62%	México	69%	(years)	10%
Age	13-19	11%	Guatemala	9%	1- 3	28%
	20-29	49%	Honduras	10%	4- 6	22%
	30-39	25%	Puerto Rico	6%	7- 9	31%
	40-49	9%	Colombia	2%	9- 12	8%
	50-59	5%	El Salvador	1%	College	1%
	60-69	1%	Others	4%	None	

Findings in Risk Detection:

48% of the participants use alcohol. The consumption of alcohol is seen as a contributing factor to HIV risk due to their living conditions. A great number of Hispanics are living away from their immediate families and generally share housing with other males. In these circumstances it is common for them to hire prostitutes who engage in sexual relations with all the residents of the house. Therefore, out of boredom and away from the social restraints of their culture and families, they drink excessively, which leads them to perform acts they typically wouldn't do. The alcohol is a generator of risky behaviors like unprotected sex, sexual promiscuity and drug use. 42% answered "No" to the use of condoms, and a disturbing 44% answered "No" or "I don't know" to the question "Do you protect yourself from HIV/AIDS?" 17% admitted to have two or more sexual partners. 10%of the total have used. 4% use cocaine and 2% admitted to injected drug use.

Findings HIV Awareness:

A disturbing 55% of the total answered "No" or "Just a little" to "are you informed about HIV?" This is a direct result of a lack of culturally appropriate outreach and information. Other agencies that have attempted to educate Hispanics did not take into account the cultural differences, the diversity within the Hispanic population, and the literature was not designed with Hispanics in mind, The consequences of such actions are that 21% consider themselves at risk of HIV and 31% are not sure if they are at risk.

An alarming 60% said they didn't know the difference between HIV and AIDS. We found that a generous percentage of the remaining 40% had misconceptions and erroneous knowledge about HIV.

The key to preventing this lack of knowledge is to educate the emerging population. While the numbers are growing fast, the numbers are still small enough that successful outreach is possible. Thus preventing an HIV explosion in the Hispanic population.

Subpopulations:

- HIV Negative Partners of HIV Positive Persons
- Farmworkers (Latino/a)
- Migrant Farmworkers (Latino)
- Sex Workers (Latina)

Needs Assessment:

–Language and cultural barriers
–Low SES (education, income, employment)
–Transportation barriers
–Lack of health insurance
–Limited or no target-population specific programming and outreach

Risk Behavior: Unprotected Sex

Intervention Goals/Outcomes:

1) Abstain/postpone sexual intercourse, 2) Increase the correct and consistent use of condoms, 3) Reduce number of sexual partners, 4) Increase knowledge of their HIV status, 5) Reduce substance use/abuse in sexual situations

* For interventions specific to HIV positive persons and injection drug users see Intervention Recommendation Sheets for populations #1 and #6.

INTERVENTION TYPES Note: Refer to "*HIV Prevention Programs Quality Assurance Guidelines*" for more detailed information on specific intervention types.	**WHY?** Note: Despite the fact that the AIDS epidemic has been devastating the Latino community for many years, there are still few proven strategies for HIV prevention. (10, **16**)
A. Individual Level Interventions (ILI)	ILI: CDC recognized as an effective intervention. (**13**)
B. Group Level Interventions – Skills Building (GLI-SB)	GLI – SB: Interventions should naturally include the skills building that has proven helpful with other groups, but they must also address the difficult cultural issues facing Latinos. CDC recognized as an effective intervention. (**11**)
C. Group Level Interventions - Support Group (GLI – SG)	GLI – SG: One intervention with gay and bisexual Latino men uses four structured small group discussions with ongoing support groups and asks group members to keep diaries of their sexual episodes. (**16**)
D. Outreach (OUT)	OUT: Outreach and engagement of immigrant and migrant populations. (12, **15**)
E. Counseling and Testing (CT) – includes Community Based Counseling and Testing (CBC&T)	CT: CDC required. (**14**)
F. Health Communication/Public Information (HC/PI)	HC/PI: Create public information and awareness campaigns that educate Latinos about their rights and entitlements as well as the availability and location of services locally. (8, 9, **10**)
G. Capacity Building (CB)	CB: Build and support local, community-based capacity. (**10**) *Note: Numbers represent references in resource section below.* ***Bold typed*** *number above indicates primary reference or resource.*

Resources:

Group Level Interventions – Skills Building

1. **Title:** *American Red Cross Hispanic HIV Education and Prevention Instructor Course*
   Description: This course trains instructors to facilitate pláticas (community HIV prevention and education sessions) using strategies such as role-plays, task groups, demonstrations and practice. Initially, pláticas may focus on sharing basic HIV/AIDS facts and personalizing these facts with the participants. Follow-up pláticas emphasize developing skills including practicing putting on and removing a latex condom, effective communication, negotiation, decision-making and community mobilization.
   Contact: James Harris, Jr., DHEC STD/HIV Division Training Coordinator, @ (803) 898-0480 or your local American Red Cross chapter

2. **Title:** *Ciruculos de Salud (Health Circles)*
   Description: This curriculum uses participatory health circles that provide participants with basic information on HIV transmission and prevention, and then involves the participants in active problem-solving discussions in response to a set of questions posed to the circle regarding risky situations and issues relevant to the lives of the participants.
   Contact: University of California - Berkeley

   Note:
   This curriculum is currently being pilot tested by the University of California - Berkeley and the manuscript is unpublished.

3. **Title:** *Hermanos de Luna y del Sol (Brothers of the Moon and Sun)*
   Description: This curriculum intervenes in a culturally appropriate manner and addresses: low self-esteem, perceptions of low sexual control, and fatalism regarding inevitability of HIV infection.
   Contact: Center for Community Research/SFSU, rmdiaz@sfsu.ed or 415-552-1013

4. **Title:** *Nosotros Viviremos (We Will Live)*
   Description: A curriculum that addresses racism, poverty, sexism, homophobia and AIDS stigma with full awareness
   Contact: Manos a la Obra (Migrant Assistance Networks for Optimum Systems) or National Coalition of Advocates for Students (NCAS) www.ncasboston.org or (915) 833-8184

5. **Title:** *Nosotras Vivremos (We will Live) – for Women Farmworkers*
   Description: This curriculum focuses on: Basic HIV and female reproduction information, gender pride, negotiation skills, and communication skills. There are two versions for women: 1) Adolescent female farmworkers, and 2) Farmworking mothers.
   Contact: Manos a la Obra (Migrant Assistance Networks for Optimum Systems) or National Coalition of Advocates for Students (NCAS) www.ncasboston.org or (915) 833-8184

6. **Title:** *El Camino Hacia la Salud (The Way Towards Good Health)*

Description: This multiple sessions curriculum addresses HIV transmission, high-risk behaviors, self-esteem issues and conflict resolutions. Numerous exercises are used to practice, laugh, and learn.
Contact: NAF Multicultural Human Development @ (402) 434-2821

Outreach

7. **Title:** *PROMISE (Peers Reaching Out and Modeling Intervention Strategies)*
   Description: This peer-based intervention, where members of the target population provide most of the outreach. It consists of role-model stories, peer advocates and prevention materials.
   Contact:

Health Communication/Public Information

8. **Title:** *Fotonovelas (Comic book soap operas)/Radionovelas (Radio broadcasted soap operas)*
   Description: Uses continuing scenarios of the same characters experiencing dilemmas associated with HIV transmission. Radio listeners are given program times and encouraged to tune-in.
   Contact: Rural Women's Health Project @ rwhp@cafl.com

9. **Title:** *Teatro Campesino (Farm Worker Theater)*
   Description: Contains politically charged, humorous, educational messages. The audience has been frequently invited into the skit to act-out their lived experiences.
   Contact:

Other

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